ORAL HEALTH CENTRE
OF WESTERN AUSTRALIA

# Form 70

## Endodontic Examination

**Use Patient Barcode Label**

Given Name _____
Surname _____
DOB _____
TEMP _____

| Clinician Name: | Clinician ID: | Supervisor Name: (If student clinician) | Supervisor ID: |
|---|---|---|---|
| | | | |

| **Tooth/Teeth FDI No's:** | **Date of examination:** |
|---|---|
| **Reason for Referral or Attendance:** | |
| | |

**Presenting Complaint:** ☐ No pain ☐ Other problems: _____

☐ *Pain:* Commenced: _____ Duration/course: _____

☐ Dull ache ☐ Throbbing ☐ Cold ☐ Biting ☐ Lingering – How long?: _____ mins
☐ Sharp pain ☐ Spontaneous ☐ Heat ☐ Pressure ☐ Wakes at night
☐ Worse lying down ☐ Any other stimulus _____

**General Notes and History:** _____

_____

**Past Pain History:** ☐ None ☐ Other notes: _____

☐ *Pain:* Commenced: _____ Duration/course: _____

☐ Dull ache ☐ Throbbing ☐ Cold ☐ Biting ☐ Lingering – How long?: _____ mins
☐ Sharp pain ☐ Spontaneous ☐ Heat ☐ Pressure ☐ Woke at night
☐ Worse lying down ☐ Any other stimulus _____

☐ **Endo started prior to referral** – by whom: _____

☐ **Previous Endo:** Tooth: _____ When: _____ By whom: _____
Retreat: _____ When: _____ By whom: _____
Surgery: _____ When: _____ By whom: _____

| | | 8 | 7 | 6 | 5 | 4 | 3 | 2 | 1 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Gr 0, I, II, III **Mobility** | | | | | | | | | | | | | | | | | |
| Tender to **Palpation** | | | | | | | | | | | | | | | | | |
| Tender to **Percussion** | | | | | | | | | | | | | | | | | |
| **Pulp Sensibility Tests** | Heat | | | | | | | | | | | | | | | | |
| | $CO_2$ | | | | | | | | | | | | | | | | |
| | Electric | | | | | | | | | | | | | | | | |
| | | 8 | 7 | 6 | 5 | 4 | 3 | 2 | 1 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| **Pulp Sensibility Tests** | Electric | | | | | | | | | | | | | | | | |
| | $CO_2$ | | | | | | | | | | | | | | | | |
| | Heat | | | | | | | | | | | | | | | | |
| Tender to **Percussion** | | | | | | | | | | | | | | | | | |
| Tender to **Palpation** | | | | | | | | | | | | | | | | | |
| Gr 0, I, II, III **Mobility** | | | | | | | | | | | | | | | | | |

Do not write within this shaded area

Form 70

# Form 70 Endodontic Examination *continuation*

**Findings:** ☐ *Discolouration of tooth:* _____ ☐ *Draining sinus:* _____
Tooth and colour — Location

☐ *Caries:* _____ ☐ *Restoration(s):* _____
Tooth and surfaces — Material, quality and surfaces

*Fractures:* ☐ **Restoration(s)** ☐ **Tooth:** ☐ Crown and/or ☐ Root

*Cracks* (surfaces): _____ *Enamel infractions* (surfaces): _____

*Swelling:* ☐ None ☐ Diffuse ☐ Localised Region: _____

☐ Hard ☐ Soft ☐ Fluctuant Tender: ☐ to palpate ☐ to pressure

*Occlusion:* ☐ Traumatic occlusion (teeth): _____

☐ Tenderness of masticatory muscles (muscles): _____

***Periodontal status:*** Local: _____ General: _____

**Radiographic Report:**

*Films viewed:* ☐ PA's: _____ ☐ BW's: _____ ☐ OPG: _____
Date(s) — Date(s) — Date(s)

_____

_____

_____

_____

**Diagnoses:** _____

_____

_____

**Cause(s):** _____

_____

_____

**Management Plan:** _____

_____

_____

**Prognosis:** ☐ Reassess after treatment/review ☐ Good ☐ Fair ☐ Poor ☐ Hopeless *(advise Exo)*

**Probable restoration required:** _____

Any alternative restoration(s) possible? List type(s): _____

**Recommendations for other treatment:** _____

_____

_____

**Other notes:** _____

_____

_____

| Clinician Signature: | Clinician ID: | Supervisor Signature: (If student clinician) | Supervisor ID: |
|---|---|---|---|
| | | | |